Scott Gibson, MSW, LCSW

Date_____

Intake Form

Client's Name First Name _____ Middle _____ Last _____ ☐ Male ☐ Female

Spouse's Name First Name _____ Middle _____ Last _____ ☐ Male ☐ Female

Address _____

City _____ **State** _____ **Zip** _____

Home Phone ( ) _____ **Work Phone** ( ) _____ **Cell Phone** ( ) _____

Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Other

Highest Level of Education _____ **Religious Affiliation** _____

Occupation / Business _____

How did you hear about me? _____

Personal & Family History:

Client's Immediate Family Members:

Name	Relationship	Age		Name	Relationship	Age

Please describe any history of physical or mental health issues either in your current family or in your family of origin:

_____

Any history of addictions? ☐ Yes ☐ No Give Details: _____

Have you ever had psychotherapy before? ☐ Yes ☐ No Reason: _____

Name of Therapist: _____ Dates: _____

Are you currently on any medications? ☐ Yes ☐ No

Medication:		Prescribed By:		Dosage:		Date(s) of usage:	
Medication:		Prescribed By:		Dosage:		Date(s) of usage:	

Any significant health changes in the past year? ☐ Yes ☐ No Reason:

What brings you to therapy at this time?

Notice of Privacy Practices, Payment & Cancellation Policies
Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Scott Gibson's Notice of Privacy Practices, Payment & cancellation policies. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Scott Gibson at 847-381-2700 x112 or 1531 South Grove, Suite 204, Barrington, IL 60010

Signature of Patient / Client Date

Signature of Parent, Guardian or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient / Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date